Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Hospital for Specialized Surgery

Respondent Name
Graphic Arts Mutual Insurance

MFDR Tracking Number
M4-14-0961-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Texas Insurance Code – Sec. 1305.353 Notice of Certain Utilization Review Determinations: Preauthorization requirements (h) Treatments and Services for an emergency do not require preauthorization."

Amount in Dispute: $20,230.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "it is the carrier's position that the procedures at issue were not a medical emergency, that adequate time and notice was available to the health care providers in March 2013 for the prior authorization process to take place, and that the provider, therefore, was required to obtain prior authorization but failed to do so.."

Response Submitted by: Utica National Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 18 -22, 2013	Outpatient Hospital Services	$20,230.62	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/Authorization/Notification absent
   - 18 – Exact duplicate claim/service

Issues

1. Does the disputed service(s) meet the definition of emergency service?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor states, "Treatments and Services for an emergency do not require preauthorization." 28 Texas Administrative Code §133.2(4)(A) states that, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
    a. Operative Report dated, March 18, 2013, states, "We previously debrided him on Friday very thoroughly, packed him open and dressed and he comes back now. He was given the choice and opportunity of either pursuing a daily dressing changes regimen to maintain the wound hygiene while waiting for adequate amount of antibiotics into the system before closure versus the alternative strategy of staged serial debridements with longer spacing in between. With the full choice available to him, the patient has elected the stage debridements as his method."

   The Division concludes the requestor's position is not supported.

2. The requestor did not support the definition of medical emergency. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.